



# Application For Workers' Compensation Insurance

1 INSURANCE AGENT OR BROKER INFORMATION					Please Print or Type	
NAME		E-MAIL ADDRESS		AREA CODE ( )	PHONE NUMBER	EXT.
ADDRESS				AREA CODE ( )	AGENT'S FAX NUMBER	
CITY	STATE	ZIP CODE	AGENCY CODE	NUMBER	DO YOU WANT COPY OF INFORMATION PAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO	

2 APPLICANT INFORMATION						
COMPLETE LEGAL NAME OF APPLICANT					E-MAIL ADDRESS	
MAILING ADDRESS - STREET OR P.O. BOX LOCATION				AREA CODE ( )	PHONE NUMBER	EXT.
CITY - STATE - ZIP CODE				AREA CODE ( )	FAX NUMBER	
LEGAL ENTITY	<input type="checkbox"/> CORPORATION	<input type="checkbox"/> GOVERNMENT	<input type="checkbox"/> LTD. LIABILITY PART.	FEDERAL ID NO.		SIC CODE
<input type="checkbox"/> SOLE PROPRIETOR	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> JOINT VENTURE	<input type="checkbox"/> LTD. LIABILITY CO.	NCCI RISK ID NUMBER		BUSINESS START YEAR
<input type="checkbox"/> UNINCORPORATED ASSN.	<input type="checkbox"/> DEBTOR IN POSSN	<input type="checkbox"/> ESTATE - TRUST	<input type="checkbox"/> _____			

3 POLICY INFORMATION										
PROPOSED EFF. DATE (M / D / Y)		PROPOSED EXP. DATE (M / D / Y)		NORMAL ANNIVERSARY DATE		DIVIDEND PLAN/SAFETY GROUP NUMBER				
PART 1 - WORKERS COMPENSATION (States)	PART 2 - EMPLOYER'S LIABILITY			PREMIUM PAYMENT PLAN - Circle one selection			PREMIUM FINANCED			
	\$	EACH ACCIDENT		1	2	4	6	9	10	<input type="checkbox"/> YES <input type="checkbox"/> NO
	\$	DISEASE-POLICY LIMIT		<b>A \$5 installment fee will be billed for all payment plans except 1.</b>						If yes - please include a copy of your finance agreement.
\$	DISEASE-EACH EMPLOYEE									
AUDIT FREQUENCY				UNDERWRITER:			APPLICATION NO.:			
<input type="checkbox"/> ANNUAL <input type="checkbox"/> SEMI-ANNUAL <input type="checkbox"/> QUARTERLY <input type="checkbox"/> MONTHLY										

NOTE AS TO EFFECTIVE DATE: If this application is accepted and approved, coverage will become effective 12:01 A.M. local time the day following postmark of the envelope containing the application and check for deposit. If the postmark is missing or obliterated, coverage will be effective at 12:01 A.M. on the day received. If the accepted application is delivered to the Fund other than by mail, coverage will be effective at 12:01 A.M. on the day following delivery.

4 RATING INFORMATION							
CLASS CODE	CATEGORIES, DUTIES, CLASSIFICATIONS			AVERAGE NUMBER OF EMPLOYEES	ESTIMATED ANNUAL REMUNERATION	RATE PER \$100 OF PAYROLL	ESTIMATED ANNUAL PREMIUM
SPECIFY ADDITIONAL COVERAGES/ENDORSEMENTS				SUB-TOTAL		\$	
				INCREASED LIMITS		\$	
				EXPERIENCE MODIFICATION		\$	
				LOSS CONTROL INCENTIVE		\$	
				PREMIUM DISCOUNT		\$	
				DEDUCTIBLE		\$	
				EXPENSE CONSTANT		\$	
				<b>TOTAL EST. ANNUAL PREMIUM</b>		\$	
POLICY MINIMUM PREMIUM \$				<b>INITIAL PREMIUM DUE</b>		\$	

## 5 OWNERSHIP

List below complete information for all officers, partners or sole proprietors. Remuneration must be part of rating information shown in Item 4.

FIRST NAME - MIDDLE NAME - LAST NAME	DATE OF BIRTH	TITLE RELATIONSHIP	OWNER SHIP %	DUTIES	INC-EXCL	CLASS CODE	REMUNERATION
A.							
SOCIAL SECURITY #							
B.							
SOCIAL SECURITY #							
C.							
SOCIAL SECURITY #							
D.							
SOCIAL SECURITY #							
E.							
SOCIAL SECURITY #							

## 6 WORKPLACES IN MARYLAND

A. PRIMARY ADDRESS (Not P.O. Box) Please list if different than mailing address.

City	State	ZIP Code	Area Code - Phone Number - Ext.
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B. PAYROLL RECORDS LOCATION Please list if different than mailing address.

City	State	ZIP Code	Area Code - Phone Number - Ext.
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C. OTHER WORKPLACES IN MARYLAND - STREET ADDRESS

Street Address	City	State	ZIP Code	Area Code - Phone Number - Ext.
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## 7 PRIOR CARRIER INFORMATION / LOSS HISTORY

YEAR	CARRIER NAME	POLICY NUMBER	ANNUAL PREMIUM	MOD	#CLAIMS	AMOUNT PAID	RESERVE

## 8 TRADE NAMES

THE APPLICANT IS OPERATING UNDER THE FOLLOWING TRADE NAMES:

## 9 NATURE OF BUSINESS / DESCRIPTION OF OPERATIONS

Give comments and descriptions of business, operations and products: Manufacturing - Raw materials, processes, product, equipment. Contractor - type of work, subcontracts. Mercantile - merchandise, customers, deliveries. Service - type, location. Farm - acreage, animals, machinery, subcontracts.

## 10 GENERAL INFORMATION

EXPLAIN ALL "YES" RESPONSES	YES	NO		YES	NO
1. Does applicant own, operate or lease aircraft or watercraft?			14. Are athletic teams sponsored?		
2. Do or have past, present or discontinued operations involve(d) storing, treating, discharging, applying, disposing, or transporting of hazardous material? (e.g. landfills, wastes, fuel tanks, etc.)			15. Are physicals required after offers of employment are made?		
			16. Any coverage declined/cancelled/non-renewed (last 3 years)?		
3. Any work performed underground or above 15 feet?			17. Are employee health plans provided?		
4. Any work performed on barges, vessels, docks, bridge over water?			18. Is there a labor interchange with any other business/subsidiary?		
5. Is applicant engaged in any other type of business?			19. Do you lease employees to or from other employers?		
6. Are subcontractors used?			20. Do any employees predominantly work at home?		
7. Any work sublet without certificates of insurance?			<b>CONTACT INFORMATION</b>		
8. Is a formal safety program in operation?			<b>INSPECTION</b>	PHONE:	
9. Any group transportation provided?				NAME:	
10. Any part time or seasonal employees?			<b>ACCOUNTING RECORDS</b>	PHONE:	
11. Is there any volunteer or donated labor?				NAME:	
12. Any employees with physical disabilities?			<b>CLAIMS INFORMATION</b>	PHONE:	
13. Do employees travel out of state?				NAME:	

### REMARKS

**11 RELATED ENTITIES**

An entity's experience and financial obligations to IWIF may continue to another entity if the entities have shared business operations, board members, officers or owners.

(A) Within the past five years, has applicant (including any owner, director or officer) been an owner, director or officer of any other entity whose business was the same or similar to the business or operations of the applicant?

\_\_\_\_\_ YES \_\_\_\_\_ NO

(B) Has applicant assumed any portion of the business or operations of any other entity through purchase, transfer, asset purchase, merger, consolidation, bankruptcy or dissolution?

\_\_\_\_\_ YES \_\_\_\_\_ NO

If the answer to A or B is YES, please identify the other entity and describe the relationship.

\_\_\_\_\_  
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\_\_\_\_\_

**IMPORTANT INSTRUCTIONS PERTAINING TO APPLICATION**

The personal information being requested in the enclosed application is being collected for underwriting purposes. IWIF cannot issue a policy of insurance unless the requested information is provided. You have a right to inspect, amend, or correct this record. This information is generally not available for public inspection but could be made available or shared with other entities to facilitate our business needs.

1. Please carefully complete this application. **It is very important that all social security numbers are entered for each officer or partner. Include Federal I.D. # where applicable.**
2. Complete a separate application for each separate legal entity to be insured by IWIF.
3. Sign the completed application and return it to the Injured Workers' Insurance Fund accompanied by the required deposit.  
Injured Workers' Insurance Fund  
8722 Loch Raven Blvd.  
Towson, MD 21286-2235
4. If your corporation is a Maryland Close Corporation and the officers wish to be excluded from coverage, please enclose a copy of your Articles of Incorporation, which have been approved by The Dept. of Assessments and Taxation, and a signed statement from each officer requesting they not be covered by the policy. This documentation must also be filed with the Worker's Compensation Commission, ATTN: Insurance Division, 10 East Baltimore Street, Baltimore, Maryland 21202-1641.
5. Attach a copy of your most recent 3 year loss report.

**6. I understand that IWIF will rely on the information contained in this application to determine the proper premium and that any false, misleading or incomplete information may constitute insurance fraud, subjecting me to criminal prosecution. By signing this application, I am certifying that the information in this application is true, accurate and complete to the best of my knowledge, information and belief.**

APPLICANT'S SIGNATURE

PRODUCER'S SIGNATURE

The items listed below may greatly affect the premium that you pay. Read this information carefully and discuss any item that you do not understand with your IWIF representative prior to signing and dating below. Keep a copy for your reference.

## REPORTABLE AS A BASIS FOR PREMIUM

The gross amounts paid by your business on the items below are to be reported when filing premium or payroll reports.

- Corporate officers' wages - subject to minimum and maximum limitations.
- Payments to contractors - unless certificates of workers' compensation insurance are obtained.
- Contract, part-time or day labor working in your normal business operations.
- Overtime - report all hours at straight time rate.
- Commissions, bonuses, holiday, vacation and sick pay.
- Tax deferred payments such as cafeteria or 401k plans.
- Payments to minors and family members.
- Rental value of an apartment or house provided to an employee.
- Car and tool allowances.
- Entertainers and musicians.

## NON REPORTABLE AS A BASIS FOR PREMIUM

Do not include these items in the gross amounts on your premium or payroll report.

- Tips or severance payments.
- Extra pay for overtime - do not report the half-time on time and one-half.
- Reimbursed expenses shown in the business records.
- Wages of owners / officers rejecting workers' compensation and excluded by endorsement.

## CONSTRUCTION TIME CARDING

Construction industry policies with more than one class code require timecard summaries by class code in order to take advantage of any lower-rated classifications. All payroll is to be reported under the highest rated classification to which the employee is working if timecard summaries are not maintained. Allocation of payroll by percentage or estimate is not allowed.

## CODES 8742 and 8810

The following requirements must be met for either Code 8742 or 8810 to apply to your policy.

8810 - Clerical Office Employees - are employees engaged exclusively in office work having no other duties relating to the operation of the business. The office must be physically separate from the other business operations and these employees will supervise only other clerical office employees.

8742 - Salespersons, Collectors, Messengers - Outside - are employees engaged in duties away from your premises. These employees will supervise only other clerical office employees.

**I have read the information above. All items were discussed that were not clear to me.  
I understand my premium responsibilities relating to this information.**

\_\_\_\_\_  
Owner/Partner/Corp. Officer  
(Signature)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Print Title)